Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Alta Vista Healthcare 5445 La Sierra Drive # 204 Dallas, TX 75231	MFDR Tracking #: M4-08-0766-01 DWC Claim # Injured Emplo
Respondent Name and Box #: Zurich American Insurance Company Rep Box # 19	Date of Injury Employer Nan Insurance Carr

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DO

Requestor's Position Summary: "In summary, it is our position that Gallagher Bassett has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered to …"

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $15,237.49
3. CMS 1500(s)
4. EOB(s)

TDI/DWC RECEIVED
FEB 14 2008
MEDICAL DISPUTE RESOLUTION

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: No position summary was submitted by the Respondent.

Principle Documentation: Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Code(s) and Calculations	Denial Code(s)	Part V Reference	Amount Ordered
02-12-07	90801	W11	1 - 3	$173.84
02-12-07	97750-FC (1 unit @ $33.14 x 12 units)	W11	1 - 3	$397.68
02-13-07 to 04-12-07	97545-WH-CA ($128.00 x 31 DOS)	W11	1, 2 & 4	$3,968.00
02-13-07 to 04-12-07	97546-WH-CA $384.00 x 11 DOS $352.00 x 11 DOS $320.00 x 5 DOS $256.00 x 2 DOS $288.00 x 1 DOS $192.00 x 1 DOS	W11	1, 2 & 4	$4,224.00 $3,872.00 $1,600.00 $512.00 $288.00 $192.00
Total Due				$15,227.52

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, sets out the reimbursement guidelines.

1. These services were denied by the Respondent with denial code "W11" – Entitlement to benefits. Not finally adjudicated.

2. A Contested Case Hearing was held on 04-05-07 at which time it was determined that the Claimant sustained a compensable injury on 07-27-2006. The carrier was ordered to pay benefits. An Appeal Panel upheld the Contested Case Hearing Findings. Therefore, this review will be according to the Medical Fee Guideline.

3. Per review of Box 32 on CMS-1500, zip code 78212 is located in Bexar County. The maximum reimbursement amount, under Rule 134.202(c)(1), is determined by locality.

4. Reimbursement is recommended per Rule 134.202(e)(5)(A)(i) and (e)(5)(C).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code Sec. §134.1 and 134.202
Subchapter G, Chapter 2001, Texas Government Code

PART VII: DIVISION DECISION/ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, section §413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $15,227.52 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
[redacted]	[redacted]	2-13-08

ORDER:

Authorized Signature	Manager, Medical Fee Dispute Resolution	Date
[redacted]	[redacted]	2-13-08

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.